GEORGIA DEPARTMENT OF PUBLIC HEALTH

TB Skin Test Validation Form

Name:_____

Indicate if course was: Hybrid Online/Live ___ OR **Entirely Live**_____OR **Entirely Online** _____

Date of Class		**Location (practicum)**		**Instructor (practicum)**	

Please check the appropriate line:

___MD ____PA ___ NP ____ RN ___ LPN _____ Paraprofessional ____ Epidemiologist ____Outreach Worker/CDS _____Administrative

☐ Other (specify)_____

Please check type of employment facility:

☐ Health Department	☐ Physician's Office	☐ County or City Jail
☐ Hospital	☐ Out Patient Clinic	☐ Federal Prison
☐ Nursing Home	☐ Personal Care Home	☐ State DOC
☐ Mental Health	☐ HIV/AIDS affiliation	☐ Juvenile Detention
☐ Hospice	☐ Community Based Organization	☐ Other _____
☐ Substance Abuse	☐ Shelter	
☐ Home Health	☐ School	

Employer:_____ Job Title_____

Employer address:_____

City:_____ State:_____ Zip:_____

Work Phone:_____ Fax:_____ Home Phone:_____

Email:_____

Date of TST Administration	Signature/ phone # of Person Observing & Verifying Competency	Check if competent	**Date of TST Reading**	Signature/ phone # of Person Observing & Verifying Competency	Check if competent

Please scan completed form and e-mail to: **TBNurse@dph.ga.gov**

- **KEEP COPY FOR YOUR RECORDS!**

(Rev. 03/2023)